DEVELOPMENTAL DISABILITIES

Missouri Department of Mental Health

DIVISION OF DEVELOPMENTAL DISABILITIES

Contract Provider Enrollment Application and Business Proposal

Read All Materials Carefully Before Beginning

General Information

All individuals or organizations seeking to establish a contract with the Department of Mental Health (DMH), Division of Developmental Disabilities (Division of DD), must complete the DMH Contract Provider Enrollment Application and Business Proposal (hereafter referred to as the "provider application". Completion of the provider application does not guarantee approval for a contract or that referrals for services will be received if a contract is established. Before beginning the provider application, refer to Division of Developmental Disabilities Directive Number 5.060, "Enrollment of New Providers" for additional information and requirements pertaining to the provider enrollment process. You may access this document at: http://dmh.mo.gov/dd/directives/directives.html

Parties considering submitting a provider application **must** first contact the Regional Office Provider Relations Coordinator to discuss service needs in their area; receive forms for an FBI background check (more information about the FBI background check is contained throughout this document) and a list of Frequently Asked Questions. See Appendix I of this document for Regional Office and Provider Relation Coordinator contact information.

Applications must be submitted to the Regional Office for which services will be provided. If you intend to serve multiple Regional Offices, the application must be submitted to the office where services will be initiated. **Do not submit an application to multiple Regional Offices.**

Completion of the provider application is solely the responsibility of the applicant. Division of DD staff may provide information about the provider enrollment process and service needs but may not provide legal, technical, financial or other business information. Applicants are expected to obtain information about such topics independent of Division of DD staff and should submit their application only after thoroughly researching all business issues.

A Federal Bureau of Investigation (FBI) fingerprint background check is required for individual applicants and members of organization applicants as specified in the provider application. The FBI background check will include a complete check of Missouri records, sex offender registry information and federal criminal history record information from all submitting law enforcement entities throughout the United States. Background reports received from the FBI are considered the property of the DMH. As such, they are stored in confidential files and subject to disclosure and retention practices specified by State and Federal law. Neither copies of the reports nor details included in the reports will be disclosed to the applicant unless the applicant is the subject of the report. Provider applications will not be processed until all required FBI background checks are received by the Regional Office. Refer to Appendix II for information about how to obtain FBI background checks. Refer to Appendix III for information regarding the purpose of the FBI background check, procedures to challenge the findings and notification of privacy rights.

All information specified in the provider application must be included upon submission. Incomplete provider applications will not be reviewed by Division of DD staff and will be returned to the applicant. Submission of an incomplete provider application will significantly delay the processing of the application and may result in termination of the applicant's request to establish a contract with the Division of DD.

For the purpose of the provider application, a single party proposing to provide services is considered an individual applicant. An entity employing one or more persons to conduct the proposed service is considered an organization. Certain sections of the provider application apply only to an individual applicant while others apply only to an organization applicant. These sections are marked accordingly.

Provider applications and related materials submitted to and accepted by the Division of DD become the property of the Division of DD and will not be returned to the applicant. The Division of DD is not responsible for making copies of provider applications. Applicants should retain a copy of all materials submitted for their records.

Organization of Application Document
The application consists of seven sections and two appendices. They are:

- Section I – Applicant Information
- Section II – Certified, Accredited and Related Services
- Section III – Professional Services
- Section IV – Non-Treatment Support Services
- Section V – Consumer Rights
- Section VI – Conflict of Interest
- Section VII – Applicant Certification
- Appendix I – Regional Office Contacts
- Appendix II – FBI Background Check Information
- Appendix III – FBI Background Check – Applicant Notification of Purpose, Challenge of Findings and Privacy

Sections I, V, VI, and VII must be completed by all applicants. Depending on the services proposed, applicants will also complete Section II **or** Section III **or** Section IV **or** any combination of these sections.

Special Procedures for Employees of the State of Missouri
Applicants must disclose if they are employees of the State of Missouri. Employees of the State of Missouri must demonstrate their application and possible resulting contract does not pose a perceived or actual conflict of interest. Section VI of the provider application applies only to employees of the State of Missouri and contains additional requirements for Missouri State employees to assure a conflict of interest does not exist.

Instructions for Completion of the Application Document
Reminder, before beginning the application process, review Directive Number 5.060, "Enrollment of New Providers", located at: http://dmh.mo.gov/dd/directives/directives.html After review of this Directive, carefully follow the instructions below and those contained within the application document.

- Download the provider application from the DMH website and save a copy to your computer.
- Complete all fields with the information requested; gray text fields will expand as needed.
- Some items require additional documents to verify the information listed in the provider application. These items are identified in the provider application using **bold, red font**. These documents, referred to as attachments, must be labeled as indicated in the provider application and submitted in order at the end of the application.
- An incomplete or disorganized provider application will be returned to the applicant without review by Division of DD staff. Submission of an incomplete or disorganized provider application will extend the processing time required and may result in the termination of the applicant's request to establish a contract.
- Request the FBI background check **two weeks** prior to the submission of the provider application to the Regional Office.
- Be sure to sign your application.
- Submit the completed provider application to the Provider Relations staff at the Regional Office serving the geographic area in which the applicant proposes to initiate services. See Appendix II of this document for Regional Office and Provider Relations Coordinator contact information.

Application Evaluation

The completed application packet is reviewed to ensure standard requirements are met. If required components are missing, the application may be denied at that point with no further action. If required components are included, designated Regional Office staff using a standardized scoring system then rate the application. The scoring system evaluates the application based on Division philosophy and priorities; applicant business practices; service definition and contract requirements; the support needs of individuals served by the Division, and best practice. The maximum possible points available are represented in the application where applicable. Total points available and minimum points required to be approved for pursuit of a contract if all other requirements are met are represented at the end of each service type.

Contract Provider Enrollment Application and Business Proposal

Section I – Applicant Information

All applicants must complete Section I.

Name, Address and Contacts	
1.1	Organization or Individual name: ☐ This application is being filed by: ☐ An organization ☐ An individual applicant / independent contractor (applicant has/will have no employees)
1.2	Organization or individual mailing address and information in Missouri (applicant must have an office in Missouri or a contingent state): Name: ☐ Phone: ☐ Street: ☐ Fax: ☐ City: ☐, State: ☐ Zip Code: ☐ +4: ☐ Mailing address and information if individual or organization corporate office is located outside of Missouri: Name: ☐ Phone: ☐ Street: ☐ Fax: ☐ City: ☐, State: ☐ Zip Code: ☐ +4: ☐ ☐ Check if the individual does not reside in Missouri or organization/corporation main office is outside Missouri.
1.3	Contact person for application process: Name: ☐ Title / Role: ☐ Work & Cell Phone: ☐ Email: ☐
1.4	Organization or individual contact in Missouri if different from 1.3: Operational Contact Person: ☐ Title/Role: ☐ Phone: ☐ Email: ☐ Individual or organization contact for corporate offices located outside of Missouri if applicable: Operational Contact Person: ☐ Title/Role: ☐ Phone: ☐ Email: ☐
1.5	Organization or individual website: ☐ ☐ Check if question 1.5 does not apply.

Business Structure	
1.6	Organization's tax identification number or individuals SSN: ☐ ☐ FEIN ☐ SSN **Attach verification of tax identification number in the form of a document generated by the IRS and label as Attachment 1.6. Individuals utilizing their SSN may attach a copy of their social security card and drivers license.**
1.7	Indicate business structure: ☐ Individual / Independent Contractor (no employees) ☐ Partnership or multi-member LLC ☐ Sole Proprietor or single-owner LLC ☐ Public entity (such as public school, college or university) ☐ Corporation or LLC electing Corporate status ☐ Other: ☐
1.8	Indicate the profit status of your organization: ☐ For Profit ☐ Not For Profit
1.9	If incorporated, you must provide a list of your organization's Board of Directors. **Attach a list of your organization's Board of Directors and label as Attachment 1.9.** ☐ Check if question 1.11 does not apply.
1.10	If your organization is incorporated, submit a resolution from the Board of Directors identifying the party duly appointed with the authority to enter into a contractual relationship with the Division of DD. **Attached a copy of the Board Resolution and label as attachment 1.10.** ☐ Check if question 1.10 does not apply.
1.11	Organization or individual National Provider Identifier (NPI): ☐ **If you or your organization has an NPI assigned, attach verification of the NPI in the form of a document generated by the National Plan and Provider Enumeration System (NPPES) and label as Attachment 1.11.** Individual or organization does not have an NPI assigned. ☐
1.12	Businesses contracting with the Division of DD must be registered in good standing with the Missouri Secretary of State's office. Is your business presently registered? ☐ Yes ☐ No **Attach verification of Secretary of State registration and label as Attachment 1.12.** ☐ Check if question 1.12 does not apply.
1.13	Organizations/individuals contracting with the Division of DD must be current in filing/paying Missouri and Federal Taxes. Are you/your business current with filing/paying Taxes? ☐ Yes ☐ No **Attach verification of filing/paying Missouri and Federal Taxes for last three years and label as Attachment 1.13.**
1.14	Organizations contracting with the Division of DD must provide evidence of workman's compensation and liability insurance prior to providing services. Does your organization have a current policy for workman's compensation and liability insurance? ☐ Yes ☐ No **Attach verification of current workman's compensation and liability insurance policy and label as Attachment 1.14.**

1.15	If you/your organization are licensed, credentialed, accredited or certified, describe this in detail in the space below. At minimum, include the following information: • Name of accrediting body • License or certification number • State in which issued • Date of expiration • Service accredited **Attach a copy of most recent accreditation / licensure or certification report and label as Attachment 1.15.** ☐ Check if question 1.15 does not apply.
	Key Staff
1.16	**For organizations only.** List the names and positions of key people in your organization that will be involved with or responsible for delivery of services under a contract with Division of DD. For corporations with offices outside of Missouri, indicate corporate contact person under other. Owner(s) with 5% of more interest: Executive Director: Program Director: Degreed Professional Manager: Registered Nurse: Other: Specify position:
	Background Checks
1.17	A *current FBI background check (fingerprint) is required for individual applicants and all Owners with more than 5% interest, Executive Directors and Program Directors of organization applicants. **In the event the required FBI background check is not received within 45 days of the receipt of the provider application by the Regional Office, the application will be rejected.** * For the purpose of this application, a current FBI background check is defined as those received from the FBI no more than forty-five days prior or forty-five days after the date the application was received by the responsible Department of Mental Health Regional Office. Applicants should request the FBI check two weeks prior to the submission of the provider application to the respective Regional Office. Refer to Appendices II and III for additional information regarding FBI background checks. **Attach receipt from entity processing FBI background check as verification of the request date and label as Attachment 1.17.**
1.18	Individual applicants and organization Owners with more than 5% interest, Executive Directors and Program Directors are required to register with the Family Care Safety Registry and submit *current registry results. * For the purpose of this application, current Family Care Safety Registry results are defined as those received from the Family Care Safety Registry no more than sixty days prior to the date the application was received by the responsible Department of Mental Health Regional Office. **Attach results of Family Care Safety Registry and label as Attachment 1.18.**
1.19	Have you or anyone in your organization who will potentially have contact with consumers been convicted of a felony? ☐ Yes ☐ No If yes, provided detailed information about the conviction including but not limited to: date, state, county, court, nature and type of offense or violation and penalty imposed.

1.20	Have you or anyone in your organization who will potentially have contact with consumers had a charge of Abuse or Neglect substantiated in any state? ☐ Yes ☐ No If yes, provided detailed information about the charge including but not limited to: date, state, county, nature and type of abuse / neglect. ☐
1.21	**For organizations only.** For existing organizations, attach three letters of reference from accrediting body, state or local funding sources or others as appropriate. List the names of the entities supplying references below. *Do not submit personal references.* ☐ **Attach copies of reference letters and label as Attachment 1.21.**
1.22	**For organizations only.** For organizations under development, attach three *professional* references for the Executive Director **and** Program Director. List the names of the parties supplying references below. ☐ **Attach copies of reference letters and label as Attachment 1.22.**
1.23	**Individual applicants only.** For individual applicants, attach three *professional* references. List the names of the parties supplying references below. *Do not submit personal references*. ☐ **Attach copies of reference letters and label as Attachment 1.23.**
1.24	**Individual applicants only.** If you intend to provide services in your home, has anyone who occasionally, temporarily or permanently resides in your home been convicted of a felony? ☐ Yes ☐ No If yes, provided detailed information about the conviction including but not limited to: date, state, county, court, nature and type of offense or violation and penalty imposed: ☐
1.25	**Individual applicants only.** If you intend to provide services in your home, has anyone who occasionally, temporarily or permanently resides in your home had a charge of Abuse or Neglect substantiated in another state? ☐ Yes ☐ No If yes, provided detailed information about the charge including but not limited to: date, state, county, nature and type of abuse / neglect: ☐
Business Plan, Experience and Expertise **Possible points available in this section: 5**	
1.26	Describe in detail your/your organization experience operating a business: ☐

1.27	If you/your organization do not have experience operating a business, describe in detail how will you obtain this expertise?
1.28	Have you/your organization developed a comprehensive business plan and operation budget relative to the services you propose to provide? ☐ Yes ☐ No **Attach a copy of your business plan and operation budget and label as Attachment 1.28.**
1.29	What do you expect your initial capacity to be (number of individuals served) for each service you propose to provide?
1.30	If a contract is established with you / your organization, payment for services may not be received for up to 90 days from the date of service initiation. Cost you will incur will vary greatly depending on the service(s) you propose to provide. Cost may include staffing, purchasing / leasing property, utility costs, furnishings, food / supplies and transportation. Estimate your cost for the operation of your business for period of 90 days and explain how you will address cash flow during this period of time. **Attach verification of financial resources to cover operating expenses for a period of 90 days and label as Attachment 1.30. Verification must be in the form of a current (within 30 days of submission of application) letter from an accredited bank or other financial institution documenting a line of credit, business loan or availability of funds. Revolving credit or a loan from a private source is not recognized.**
1.31	Describe in detail you / your organization's skills and abilities that provide you with the background to operate this type of business.
1.32	List all cities and states where you / your organization previously or currently conduct business. Include any name your organization is "doing business as". ☐ Check if question 1.32 does not apply.

	Name of Organization	Address	Phone	Dates of service

1.33	Have you / your organization provided services in other states but no longer do so? ☐ Yes ☐ No If you answered "Yes", specify the state(s) involved and explain why you no longer provide services.
1.34	What types of services and supports are presently provided by you / your organization?
1.35	How long have you / your organization been providing services? ☐ Check if question 1.35 does not apply.

1.36	Have you / your organization ever had a contract for services or been employed with any State of Missouri agency? ☐ Yes ☐ No If "Yes", specify below:					
	Agency Name	Position Held	Dates of contract or employment	Name of contact/ Supervisor	Contact/ Supervisors Phone Number	Reason for contract/employ ment termination
1.37	Have you / administration of the organization ever contracted with or been employed by any Division of Developmental Disabilities contracted provider? ☐ Yes ☐ No If "Yes", specify below:					
	Agency Name	Position Held	Dates of contract or employment	Name of Contact Supervisor	Contact/ Supervisors Phone Number	Reason for contract/employ ment termination

1.38 Are any of your Board members employed by the State of Missouri? ☐ Yes ☐ No

If you answered "Yes", provide information about the Board members (name, name of State agency employed) below:

☐ Check if question 1.38 does not apply.

1.39 Do the owner and administrator and managing staff reside within 1 hour of the area they are proposing to serve?

☐ Yes ☐ No

If you answered "No", describe in detail your plan to ensure the health and safety of the individuals served and oversight/supervision of staff providing the service.

Staff Experience and Expertise
Possible points available in this section: 4

1.40 List the name(s) of the **Executive Director/Owner**. *(individual applicants skip 1.41-1.44)*

Describe (in detail) the educational background(s) of the **Executive Director/Owner**.

Attach documentation of educational background and label as Attachment 1.40.

Describe (in detail) the number of years and type of experience(s) the **Executive Director/Owner** has relative to the field of developmental disabilities and the services proposed.

Attach resume to document experience and label as Attachment 1.40.

1.41	List the name of the **Program Director(s)**. Describe (in detail) the educational background of the **Program Director(s)**. **Attach documentation of educational background and label as Attachment 1.41.** Describe (in detail) the number of years and type of experience the **Program Director(s)** has relative to the field of developmental disabilities and the services proposed. **Attach resume to document experience and label as Attachment 1.41.** ☐ Check if section 1.41 does not apply.
1.42	List the name of the **Degreed Professional Manager(s)**. Describe (in detail) the educational background of **Degreed Professional Manager(s)**. **Attach documentation of educational background and label as Attachment 1.42.** Describe (in detail) the number of years and type of experience the **Degreed Professional Manager(s)** has relative to the field of developmental disabilities and the services proposed. **Attach resume to document experience and label as Attachment 1.42.** ☐ Check if section 1.42 does not apply.
1.43	List the name of the **Registered Nurse(s)**. Describe (in detail) the educational background of the **Registered Nurse(s)**. **Attach documentation of educational background and license and label as Attachment 1.43.** Describe (in detail) the number of years and type of experience the **Registered Nurse(s)** has relative to the field of developmental disabilities and the services proposed. **Attach resume to document experience and label as Attachment 1.43.** ☐ Check if section 1.43 does not apply.
1.44	List the name(s) of **other critical personnel**. Describe (in detail) the educational background of **other critical personnel.** **Attach documentation of educational background and label as Attachment 1.44.** Describe (in detail) the experience the **other critical personnel** have relative to the field of developmental disabilities and the services proposed. **Attach resume to document experience and label as Attachment 1.44.** ☐ Check if section 1.44 does not apply.

Effective March 17, 2014, the Center for Medicaid and Medicare Services (CMS) published a final rule regarding changes to Home and Community Based Waiver Services (HCBS Waiver). **The rule is commonly referred to as the final HCBS Rule. In Missouri, this affects all Home and Community Based waiver programs.**

1.45

CMS Intent of the Rule

"To ensure that individuals receiving services and supports through the Medicaid's home and community based service (HCBS) programs have full access to benefits of community living and are able to receive services in the most integrated setting"

"designed to improve the quality of services for individuals receiving HCBS"

Effective March 17, 2014

CMS Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule:

- CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences.
- The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics.
- Requires states to submit a plan to ensure compliance of the final rule

Consumers and Advocates

- Individuals have the right to receive services in the community to the same degree as those not receiving HCB waiver services:
  - Individuals must be allowed to select the services they receive, where they live among available options, and the providers of those services.
  - Individuals have the freedom to control their own schedules, personal resources, and other aspects of their living arrangement.
  - Individuals must be treated with dignity and respect, and be free from coercion or restraint.

Final HCBS Rule Setting Requirements 42 CFR 441.301(c)(4)

- HCBS Rule requires that an HCB Waiver Service setting:
  - Is fully integrated in and supports access to the greater community
  - Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
  - Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community based services
  - Is selected by the individual from more than one setting option, including non-disability specific settings and an option for a private room in a residential setting
  - Supports individual choice of services and supports
  - Ensures privacy, dignity, respect, and freedom from coercion and restraint
  - Optimizes individual initiative, autonomy, and independence in making life choices
  - Facilitates individual choice regarding services and supports and who provides them

- **Provider Owned or Controlled Residential Settings Requirements^^**
  - Individuals have:
    - privacy in their homes
    - choice of roommates
    - freedom to furnish and decorate their sleeping or living areas within the lease or other agreement
    - freedom and support to control their schedules and activities and have access to food any time
    - visitors at any time
  - Homes have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
  - Specific dwelling is owned, rented, or occupied under a legally enforceable agreement

	○ Same responsibilities and protections from eviction as all tenants under landlord tenant law ○ Any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: • Identify a specific and individualized assessed need. • Document the positive interventions and supports used prior to any modifications to the person centered service plan. • Document less intrusive methods of meeting the need that have been tried but did not work. • Include a clear description of the condition that is directly proportionate to the specific assessed need. • Include regular collection and review of data to measure the ongoing effectiveness of the modification. • Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. • Include the informed consent of the individual. • Include an assurance that interventions and supports will cause no harm to the individual. **Final HCBS Rule Setting Requirements 42 CFR 441.301(c)(5)** • Settings that are not home and community based: ○ Nursing Facility ○ Institution for mental diseases (IMD) ○ Intermediate care facility for individuals with intellectual disabilities (ICF/ID) ○ Hospital ○ Any other locations that have qualities of an institutional setting, as determined by the Secretary Settings presumed not to be HCB (Heightened Scrutiny)^^ ○ Settings located in a publicly or privately-operated facility providing inpatient institutional treatment ○ Settings on the grounds of, or adjacent to, a public institution ○ Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCB services **Characteristics of Settings that Isolate People from the Broader Community^^** • The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or recreational activities • People in the setting have limited, if any, interaction with the broader community • Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g., seclusion) • Farmstead or disability-specific farm community • Gated/secured “community” for people with disabilities ○ These communities typically consist primarily of people with disabilities and the staff that work with them • Residential schools ○ These settings incorporate both the educational program and the residential program in the same building or in buildings in close proximity to each other
1.46	Are you in disagreement with any of the Rule described in 1.45? ☐ Yes ☐ No If “yes”, explain: ☐

Region and Services

1.47 Indicate the Division of Developmental Disabilities Region(s) you propose to serve.

☐ Albany RO	☐ Joplin RO	☐ Poplar Bluff RO	☐ Springfield RO
☐ Central Mo RO	☐ Kansas City RO	☐ Rolla RO	☐ St. Louis County RO
☐ Hannibal RO	☐ Kirksville RO	☐ Sikeston RO	☐ Tri-County RO

1.48 **CERTIFIED, ACCREDITED AND RELATED SERVICES**

Complete **Section II** of the Provider Application if applying for one or more of the following services:

- Community Employment / Supported Employment
- Community Employment: Job Discovery
- Community Employment: Job Preparation
- Independent Living Skills Development/Day Services/Day Habilitation
- Personal Assistant Services
- Residential: Shared Living (Host & Companion Home)
- Residential: Individualized Supported Living
- Respite Care: In-Home
- Respite Care: Out-of-Home
- Respite: Temporary Residential Service

Click to go directly to Section II

1.49 **PROFESSIONAL SERVICES**

Complete **Section III** of the Provider Application if applying for one or more of the following services:

- Alternative Language Translation
- Behavioral Supports: Behavior Analysis Services
- Behavioral Supports: Counseling
- Behavioral Supports: Person Centered Strategies
- Communication Skills Instruction
- Community Specialist
- Interpreting
- Parent/Caregiver Training
- Professional Assessment and Monitoring: RN
- Professional Assessment and Monitoring: LPN
- Professional Assessment and Monitoring: Dietician
- Support Broker
- Therapy: Music Therapy
- Therapy: Occupational Therapy
- Therapy: Physical Therapy
- Therapy: Speech Therapy

Click to go directly to Section III

1.50 **NON-TREATMENT SUPPORT SERVICES**

Complete **Section IV** of the Provider Application if applying for one or more of the following services:

- Assistive Technology
- Dental
- Environmental Accessibility Adaptation (home modification)
- Personal Electronic Safety Device
- Specialized Medical Equipment & Supplies
- Transportation
- Other – specify: ☐

Click to go direction to Section IV

Section II – Certified, Accredited and Related Services

Complete all of Section II if applying for one of more of the services listed in item 2.1.

Proposed Services	
2.1	Indicate the certified, accredited or related service(s) you propose to provide: ☐ Community Employment / Supported Employment ☐ Community Employment: Job Discovery ☐ Community Employment: Job Preparation ☐ Independent Living Skills Development/Day Services/Day Habilitation ☐ Personal Assistant Services ☐ Residential: Shared Living (Host & Companion Home) ☐ Residential: Individualized Supported Living ☐ Respite Care: In-Home ☐ Respite Care: Out-of-Home ☐ Respite: Temporary Residential Service
General Philosophy **Possible points available in this section: 10**	
2.2	State your/your organization's mission statement.
2.3	Describe how you / your organization will ensure individuals receive services in the community to the same degree as those not receiving services.
2.4	Describe how you / your organization will ensure you / your agency support individual choice of services and supports.
2.5	Describe how you / your organization optimizes individual initiative, autonomy, and independence in making life choices.
2.6	Describe how you / your organization provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.
2.7	**For Applicants applying for Residential Services** Describe your organization's plan to provide services in compliance with the HCBS requirements in 1.45 as indicated by the symbol ^^. Note: This symbol is indicated in three areas. ☐ Check if section 2.7 does not apply.
Challenging Behavior **Possible points available in this section: 6**	
2.8	Describe the behavioral support needs of the individuals you / your organization propose to serve.
2.9	Describe what should be considered when supporting individuals with challenging behaviors.

2.10	Describe your / your organization's number of years of experience **and** the experience/skills that will enable you to work with individuals and families to develop plans that address challenging behaviors.
2.11	Describe specialized training you / your organization has in supporting individuals with challenging behaviors.

Medical Supports
Possible points available in this section: 6

2.12	Describe the medical support needs of the individuals you / your organization propose to serve.
2.13	Describe what should be considered when supporting individuals with significant medical needs.
2.14	Describe your / your organization's number of years of experience **and** the experience/skills that will enable you to work with individuals and families to develop plans that address significant medical support needs.
2.15	Describe specialized training you / your organization has in supporting individuals with significant medical needs.

Co-Occurring Conditions
Possible points available in this section: 6

2.16	Describe the mental health and habilitative support needs of the individuals you / your organization propose to serve.
2.17	Describe what should be considered when supporting individuals with co-occurring conditions.
2.18	Describe your / your organization's number of years of experience **and** the experience/skills that will enable you to work with individuals and families to develop plans that address co-occurring conditions.
2.19	Describe specialized training you / your organization has in supporting individuals with co-occurring conditions.

SECTION II – CERTIFIED, ACCREDITED AND RELATED SERVICES SCORING

Business Plan, Experience and Expertise (from Section 1)	5 points
Staff Experience and Expertise (from Section 1)	4 points
General Philosophy	10 points
Challenging Behaviors	6 points
Medical Supports	6 points
Co-Occurring Conditions	6 points
Section II Grand Total	37 points
Minimum points required to be approved for pursuit of any other service in this section contract if all other requirements are met	25 points

Section III – Professional and Therapeutic Services

Complete all of Section III if applying for one of more of the services listed in item 3.1.

If applying for Professional Assessment and Monitoring: RN solely related to the ISL service, Section III is not required. This service is a subcomponent of the ISL service. Scoring in Section II shall apply.

Proposed Services	
3.1	Indicate the professional and therapeutic service(s) you propose to provide. ☐ Alternative Language Translation * ☐ Behavioral Supports: Behavior Analysis Services * ☐ Behavioral Supports: Counseling* ☐ Behavioral Supports: Person Centered Strategies ☐ Communication Skills Instruction ☐ Community Specialist ☐ Interpreting * ☐ Parent/Caregiver Training ☐ Professional Assessment and Monitoring: RN * ☐ Professional Assessment and Monitoring: LPN * ☐ Professional Assessment and Monitoring: Dietician * ☐ Support Broker ☐ Therapy: Music Therapy ☐ Therapy: Occupational Therapy * ☐ Therapy: Physical Therapy * ☐ Therapy: Speech Therapy * **Attach resume for each individual proposed to work under contract for the Division of DD (if not included in Section 1 Staff Experience and Expertise) and label as Attachment 3.1.** ***Attach verification that each professionally licensed staff proposed to work under contract with Division of DD (if not included in Section 1 Staff Experience and Expertise) is registered with Missouri Division of Professional Registration and label as Attachment 3.1.**

General Philosophy **Possible points available in this section: 4**	
3.2	State your/your organization's mission statement. ☐
3.3	Describe (in detail) the service/program you/your organization's provides relative to the specific service(s) indicated in 3.1. ☐
3.4	Describe how you / your organization optimizes/supports individual initiative, autonomy, and independence in making life choices. ☐

SECTION III – PROFESSIONAL AND THERAPEUTIC SERVICES SCORING

Business Plan, Experience and Expertise (from Section 1)	5 points
Staff Experience and Expertise (from Section 1)	4 points
General Philosophy	4 points
Section III Grand Total	13 points
Minimum points required to be approved for pursuit of a contract if all other requirements are met	9 points

Section IV – Non-Treatment Support Services

Complete all of Section IV if applying for one of more of the services listed in item 4.1.

If applying for Transportation solely related to the ISL service, Section IV is not required. This service is a sub-component of the ISL service. Scoring in Section II shall apply.

Proposed Services	
4.1	Indicate the non-treatment support services(s) you propose to provide. ☐ Assistive Technology ☐ Dental ☐ Environmental Accessibility Adaptation (home modification) ☐ Personal Electronic Safety Device ☐ Specialized Medical Equipment & Supplies ☐ Transportation ☐ Other – specify:

SECTION IV – NON-TREATMENT SUPPORT SERVICES SCORING	
Business Plan, Experience and Expertise (from Section 1)	5 points
Staff Experience and Expertise (from Section 1)	4 points
Section IV Grand Total	9 points
Minimum points required to be approved for pursuit of a contract if all other requirements are met	6 points

Section V – Consumer Rights

Statement of Rights	
5.1	**Individuals Served by the Missouri Department of Mental Health are afforded the following rights:** To humane care and treatment: 1. To the extent that the facilities, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice. 2. To safe and sanitary housing. 3. To not participate in non-therapeutic labor. 4. To attend or not attend religious services. 5. To receive prompt evaluation and care, treatment, habilitation or rehabilitation about which he is informed insofar as he is capable of understanding. 6. To be treated with dignity as a human being. 7. To not be the subject of experimental research without his prior written and informed consent or that of his parent, if a minor, or his guardian; except that no involuntary patient shall be subject to experimental research, except as provided within this chapter. 8. To decide not to participate or may withdraw from any research at any time for any reason. 9. To have access to consultation with a private physician at his own expense. 10. To be evaluated, treated or habilitated in the least restrictive environment. 11. To not be subjected to any hazardous treatment or surgical procedure unless he, his parent, if he is a minor, or his guardian consents; or unless such treatment or surgical procedure is ordered by a court of competent jurisdiction. 12. In the case of hazardous treatment or irreversible surgical procedures, to have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for the preservation of his life. 13. To a nourishing, well-balanced and varied diet. 14. To be free from verbal and physical abuse. (These rights listed below <u>may</u> be limited based on safety or therapeutic issues.) 1. To wear his own clothes and to keep and use his own personal possessions. 2. To keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases. 3. To communicate by sealed mail or otherwise with persons including agencies inside or outside the facility. 4. To receive visitors of his own choosing at reasonable times. 5. To have reasonable access to a telephone both to make and receive confidential calls. 6. To have access to his mental and medical records. 7. To have opportunities for physical exercise and outdoor recreation. 8. To have reasonable, prompt access to current newspapers, magazines and radio and television programming.
5.2	Are you in disagreement with any of the rights listed? ☐ Yes ☐ No If “yes”, explain: ☐

Section VI – Conflict of Interest

Disclosure of State of Missouri Employment	
6.1	Is the applicant or any key member of the applying organization an employee of the State of Missouri? ☐ Yes ☐ No If "yes" complete section 6.2; if "no" proceed to section 7.1.
Conflict Of Interest	
6.2	**For employees of the State of Missouri only.** State the Department, Division and Facility that employees you and your position: Describe your primary job duties as an employee of the State of Missouri: Review the following information pertaining to conflict of interest for employees of the State of Missouri: Conflict of interest is any action you take in your official capacity resulting in financial gain to yourself, your family, or any business in which you have an interest. This includes performing any paid services for the department other than your official duties; selling, renting, or leasing property to the department; or trying to influence official decisions which will result in financial gain to yourself or your family or a business in which you have an interest. You may not work for private gain on state property or use other state employees, supplies or equipment for your private gain. The Division of DD contract for service providers states: 1. The contractor hereby agrees that at the time of the submission of their proposal the contractor has no other contractual relationships which create any actual conflict of interest. The contractor agrees that during the term of the contract neither the contractor nor any of its employees shall acquire any other contractual relationships which would create such a conflict. 2. In accordance with the Revised Statutes of the State of Missouri, no official or employee of the Department or public official of the State of Missouri who exercises any functions or responsibilities in the review or approval of the Scope of Work covered by the contract shall acquire any personal interest, directly or indirectly, in the contract or proposed contract. 3. In accordance with state and federal laws and regulations, state executive order or regulations, the contractor agrees that it presently has no interest and shall not acquire any interest, directly or indirectly, which would conflict in any manner or degree with their performance of the contracted services. The contractor agrees that no person having such interest shall be employed or conveyed an interest, directly or indirectly, in the contract. 4. The contractor agrees that no Missouri state employee shall help the contractor obtain this contract or participate in the performance of this contract if such involvement will constitute a conflict of interest. Before any state employee may be involved in the performance of this contract written approval shall be obtained from the director of the Department. 5. The contractor agrees that no Missouri state employee shall be compensated under this contract for duties performed in the course of his/her state employment. A state employee shall not use state facilities or materials for personal gain relating to the performance of this contract.

6. The contractor represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees as employees of the State of Missouri.

7. If the contractor is a not-for-profit agency, board members must abstain from voting on any funding proposal in which they have administrative control or a monetary interest with the proposed grantee. Board members who have such an interest and participate in discussion prior to a vote must disclose such interest in a meeting of the board prior to such discussion.

I have read and understand the content of section 6.2 of the provider application and I declare no conflict as defined in section 6.2 of the provider application exists. I also understand that in accordance with item four above, approval from the Director of the Department of Mental Health will be required before a contract can be issued.

_____	_____
Print Name	Print Title
_____	_____
Signature	Date

Section VII – Applicant Certification

Application Signatures	
7.1	**Both signature sections below must be completed. The first section, "Application Certification" must be completed by the party submitting the application. The second section, "FBI Background Check Acknowledgement" must be completed by <u>each</u> person who is the subject of the FBI background check. The person signing this section may be the same or different from the person submitting the application.**

Application Certification:

May we contact your former and present employers/contractors? ☐ Yes ☐ No

If yes, your signature below authorizes any former or current employers/contractors to furnish the Department of Mental Health with any or all of information concerning your previous employment and releases any former or current employer from all liability for any damages in furnishing such information.

I hereby certify that this application contains no willful misrepresentation or falsification and the information given by me is true and complete to the best of my knowledge and belief. I am aware that should investigation at any time disclose any such misrepresentation or falsification as to material fact, my application will be rejected and / or contract voided. I acknowledge I have read and understand the information contained in Appendix III pertaining to FBI background checks.

I further acknowledge that I have read and understand the information contained in 1.45 pertaining to the HCBS Settings Rule and that I/my organization shall provide services in compliance with the Rule.

_____ _____
Print Name Print Title

_____ _____
Signature Date

FBI Background Check Acknowledgement:

I acknowledge I have read and I understand the information contained in Appendix III pertaining to FBI background checks.

_____ _____
Print Name Print Title

_____ _____
Signature Date

_____ _____
Print Name Print Title

_____ _____
Signature Date

_____ _____
Print Name Print Title

_____ _____
Signature Date

_____ _____
Print Name Print Title

_____ _____
Signature Date

Appendix I
Regional Office Contact Information

Follow this link for a map of Regional Offices Locations and Counties Served.

Regional Office	Contact Person	Mailing Address	Telephone	MACHS – Four Digit Registration Number * See note below	ORI – Originating Agency Identification ** See note below	OCA – Originating Case Agency *** See note below
Albany	Shelly Brown	809 North 13th Street Albany, MO 64402	816-726-1527	5436	MO920698Z	DD001
Central MO	Lynn Maggard	1500 Vandiver Drive Suite 100 Columbia, MO 65202	660-831-3110	5437	MO920698Z	DD002
Hannibal	Steve Laws	PO Box 1108 Hannibal, MO 63401	573-248-2400	5438	MO920698Z	DD003
Joplin	Terri Yelton	PO Box 1209 Joplin, MO 64802	417-629-3568	5439	MO920698Z	DD004
Kansas City	Jama Mahanes	PO Box 412557 Kansas City, MO 64106	816-889-3466	5440	MO920698Z	DD005
Kirksville	Lynn Maggard	1500 Vandiver Drive Suite 100 Columbia, MO 65202	660-831-3110	5437	MO920698Z	DD002
Poplar Bluff	Kevin Dilbeck	2351 Kanell Blvd Poplar Bluff, MO 63901	573-840-9350	5442	MO920698Z	DD007
Rolla	Michelle Brown	PO Box 1098 Rolla, MO 65402	573-368-2545	5443	MO920698Z	DD008
Sikeston	Chas Russo	PO Box 966 Sikeston, MO 63801	573-290-5436	5444	MO920698Z	DD009
Springfield	Lisa Price-Suttee	PO Box 5030 Springfield, MO 65801	417-895-7432	5445	MO920698Z	DD010
St. Louis County	Jane Alexander	4040 Seven Hills Drive Florissant, MO 63033	314-475-7616	5446	MO920698Z	DD011
St. Louis - Tri-County	Holly Reiff	111 North 7t Street, 6th Floor St. Louis, MO 63101	314-244-8859	5447	MO920698Z	DD012

* Used to register with the Missouri Automated Criminal History Site (MACHS) described in Appendix II.

** Used to complete the "Agency ORI" field on the "Missouri State Highway Patrol Applicant Fingerprint Services of Missouri" form described in Appendix II.

*** Used to complete the "OCA Code" field on the "Missouri State Highway Patrol Applicant Fingerprint Services of Missouri" form described in Appendix II.

Appendix II
FBI Background Screening

A FBI background check, completed no more than forty-five days prior or forty-five days after the receipt of the provider application by the responsible Department of Mental Health Regional Office, is required for all applications. Retain documentation of the date the FBI background check was requested and submit this with your application as described in section 1.17 of the provider application. In the event the responsible Regional Office does not receive the FBI background report within the specified timeframe, the provider application will be rejected.

To process the FBI background check, there are three options:

1. **3M/Cogent**
   3M/Cogent is a private contractor working in partnership with the State of Missouri to conduct Missouri State Highway Patrol and FBI background checks based on fingerprints. They have fingerprinting sites available throughout the state. The cost for 3M/Cogent services is $44.80 as of 07/01/2012.

   To be fingerprinted through 3M/Cogent, you must first register with the Missouri Automated Criminal History Site (MACHS). This is completed on-line at: www.machs.mo.gov. Once on the MACHS website, select the option that says, "Click Here to Access the MACHS Fingerprint Search Portal to schedule a background check by Fingerprints". If you do not have access to the Internet, you may contact Cogent at 1-877-862-2425 to have a Cogent representative conduct this registration on your behalf. The MACHS registration process requires you to provide a four digit registration number which you will find in Appendix I of this document. Select the number that corresponds to the Regional Office with which you will file your Provider Application.

   The brochure Missouri Applicant Processing Services Applicants User Guide for State Agency and MOVECHS Fingerprint Search Requests will provide additional information about Cogent and registration with MACHS for fingerprint services. You are strongly advised to review this brochure prior to beginning the 3M/Cogent and MACHS background check processes.

   Locations conducting fingerprints can be found at: https://www.cogentid.com/mo/index.htm.

   A list of what to bring to the fingerprinting site can be found at: https://www.cogentid.com/mo/index.htm.

2. **Highway Patrol Public Window –**
   Go in person to the Missouri State Highway Patrol's public window at the Patrol's office in Jefferson City located at:

   Missouri State Highway Patrol Public Window Access
   Annex Building 1510 East Elm Street
   Jefferson City, MO 65101

   Public Window hours are 8:00 AM to 5:00 PM, Monday through Friday (Closed on State and/or Federal Holidays).

   Applicant must provide a properly completed Missouri State Highway Patrol Applicant Fingerprint Services of Missouri form to the staff at the public window. If you elect to use this option, request this form from the local Regional Office Provider Relations staff listed in Appendix I. To properly complete this form, refer to the sample at the end of Appendix II and refer to Appendix I for:

   - Regional Office name
   - Regional Office addresses
   - Originating Agency Identification (ORI) code (same code used for all Regional Offices)
   - Originating Case Agency (OCA) codes (unique code used for each Regional Office)

   Cost for public window services is $36.50 as of 03/01/2012.

3. **Mail In –**
   Obtain an ink fingerprint card completed by local law enforcement. The ink fingerprint card must include the ORI Code: MO920698Z; the Regional Office's OCA Code (listed in Appendix I) and the reason fingerprinted must say 43.543. Applicants must also submit a properly completed Missouri State Highway Patrol Applicant Fingerprint

Services of Missouri form. If you elect to use this option, request this form from the local Regional Office Provider Relations staff listed in Appendix I. To properly complete this form, refer to the sample at the end of Appendix II and refer to Appendix I for:

- Regional Office name
- Regional Office addresses
- Originating Agency Identification (ORI) code (same code used for all Regional Offices)
- Originating Case Agency (OCA) codes (unique code used for each Regional Office)

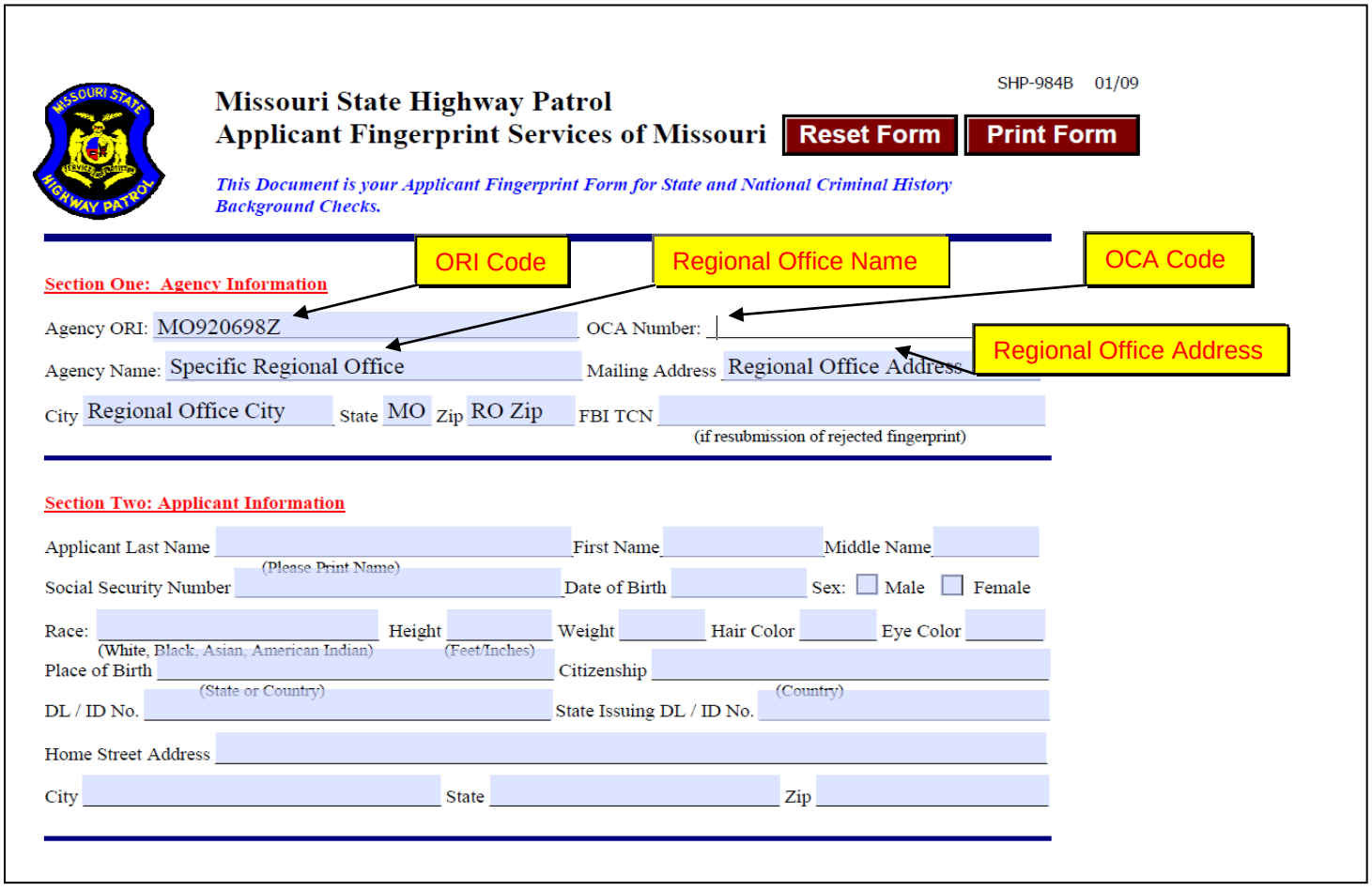
Mail completed forms to:

Missouri State Highway Patrol
1510 East Elm
PO Box 9500
Jefferson City, MO 65102
Attn: CJIS

Cost for mailed background check is $36.50 as of 03/01/2012.

Regardless of option used, the Missouri State Highway Patrol Applicant Fingerprint Services of Missouri form, completed as shown above, must be submitted. Failure to do so may delay or prevent the receipt of the FBI background screening by the Regional Office and result in the rejection of the provider application.

Sample "Missouri State Highway Patrol Applicant Fingerprint Services of Missouri" Form



Appendix III
FBI Background Check
Applicant Notification of Purpose, Challenge of Findings and Privacy Information

Governmental agencies that conduct a national fingerprint-based criminal history record check on an applicant for noncriminal purposes are obligated to ensure the applicant receives certain notification and information. By signing the **Contract Provider Enrollment Application and Business Proposal** you acknowledge that you, as the subject of the FBI background check, understand the following:

- Your fingerprints will be used to check the criminal records history of the FBI.
- The results of the FBI criminal history check will be used as part of the determination of the suitability of your application to become a contract provider for the Missouri Department of Mental Health, Division of Developmental Disabilities.
- You have the right to challenge the information in the FBI record as outlined below in the section entitled "Noncriminal Justice Applicant's Privacy Rights".
- The information received from the FBI background check will be used solely for the purpose of evaluating the **Contract Provider Enrollment Application and Business Proposal** and will not be disseminated outside the Department of Mental Health.

In addition, by signing the **Contract Provider Enrollment Application and Business Proposal** you acknowledge you, as the subject of the FBI background check, have received the following privacy information:

NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have the following rights:

- You must be notified that your fingerprints will be used to check the criminal history of record of the FBI.
- If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
- The officials must advise you that the procedures for obtaining a change, correction, or updating of you criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
- If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record. (See 28 CFR 50.12(b).)
- You have the right to expect that officials receiving the results of the criminal history record check will use it only for the authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c); 20.33(d), and 906.2(d).)
- If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provider you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov/about-us/cjis/background-checks.
- If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

If you have questions regarding the FBI Background check, contact the Provider Relations staff at the local Regional Office.